A.3

Designation Run Report

Knittle, Robert - Merged DA PC DC 7-11-21 1030p

Knittle, Robert 08-27-2020

Defendants' Affirmatives 00:57:58

Defendants' Completeness 00:02:27

Plaintiffs' Completeness 00:31:49

Total Time 01:32:14

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8:22 - 9:03	**Knittle, Robert 08-27-2020 (00:00:16)** 8:22 Q. Good morning, Mr. Knittle. I introduced 8:23 myself a little bit earlier. My name is Sandy 8:24 Zerrusen, and as I stated earlier, I represent 9:1 AmerisourceBergen Drug Corporation. Could you 9:2 please state your full name for the record? 9:3 A. Yes, my full name is Robert Clare Knittle.	VM31.1
25:20 - 26:06	**Knittle, Robert 08-27-2020 (00:00:30)** 25:20 Q. And where did you go after Pressley Ridge? 25:21 A. After that -- I was there for about 12 or 25:22 13 years, and then I moved on to the Board of 25:23 Medicine in the State of West Virginia as the 25:24 executive director there. 26:1 Q. And when did you start that position? 26:2 A. It was December of 2005. 26:3 Q. And I believe you said earlier you retired 26:4 January 1st of 2017? 26:5 A. Yes. My last day of work was December 26:6 31st, 2016.	VM31.2
26:13 - 27:09	**Knittle, Robert 08-27-2020 (00:01:16)** 26:13 Q. Perfect. During your time at the Board, 26:14 were you involved in any professional associations? 26:15 A. Yes. 26:16 Q. Okay. Which ones? 26:17 A. The Federation of State Medical Boards. 26:18 Q. Okay. Is that FSMB? 26:19 A. Yes, it is. 26:20 Q. Okay. And what was your involvement with 26:21 FSMB? 26:22 A. Represented the State of West Virginia at 26:23 the -- at a national level. I was involved in 26:24 several other aspects of the Federation Board. 27:1 Q. Can you describe to me what the Federation 27:2 of State Medical Boards is? 27:3 A. Yes. It's a organization that helps assist 27:4 state boards of medicine for the United States. 27:5 Q. And how do they help assist them? 27:6 A. They help supply organization information 27:7 that can be shared across states. They assist in 27:8 the licensing of physicians. It's	VM31.3

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	27:9 more administrative in nature.	
27:10 - 27:24	**Knittle, Robert 08-27-2020 (00:00:52)**	VM31.4
	27:10 Q. Did you find during your tenure at the 27:11 Board that FSMB was helpful for you in your 27:12 position? 27:13 A. Yes, I would -- I would say so. I think it 27:14 was a two-way street. I was -- I was involved in a 27:15 number of their projects as well. 27:16 Q. Okay. Do you remember what projects you 27:17 were involved with them in? 27:18 A. I sat on the medical directors -- state 27:19 medical directors advisory panel to the Federation 27:20 of State Medical Boards. 27:21 And I also sat on their advisory 27:22 council to the United States Medical License 27:23 Examination, USMLE, when they went through their 27:24 changes of their steps.	
28:16 - 29:05	**Knittle, Robert 08-27-2020 (00:00:46)**	VM31.5
	28:16 Q. Did any of the changes in the content that 28:17 you were involved in relate to controlled 28:18 substances or prescribing? 28:19 A. Not specifically. There may have been 28:20 questions in there that dealt with opioids or the 28:21 prescribing of them. But they were nothing that 28:22 was specifically focused on as part of the 28:23 examination. 28:24 Q. Okay. You also said that you were on an 29:1 advisory panel. What was that? 29:2 A. It was a -- basically when issues would 29:3 come up that -- at a national level, they would ask 29:4 from -- for input from different medical directors 29:5 across the country.	
29:06 - 29:19	**Knittle, Robert 08-27-2020 (00:00:57)**	VM31.6
	29:6 Q. Did -- were any of the issues that you 29:7 dealt with, did any of them relate to controlled 29:8 substances or prescribing? 29:9 A. I think there was some discussion. And I 29:10 can't be real specific about it because I can't 29:11 remember. But -- but there was talk about, you 29:12 know, some type of a template for states to look at	

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	29:13 in terms of developing policy for training and 29:14 education regarding opiates for physicians. 29:15 Q. Regarding prescribing? Excuse me. 29:16 A. Well, the whole process of -- like you were 29:17 talking about, you know, someone coming in asking 29:18 for pain management of some nature. Some were more 29:19 specific than others as to exactly what they want.	
29:20 - 29:24	**Knittle, Robert 08-27-2020 (00:00:17)** 29:20 Q. And did you participate in coming up with 29:21 this template? 29:22 A. No, I did not. 29:23 Q. Okay. All right. Were you involved with 29:24 any other professional associations while at the	VM31.7
30:01 - 30:24	**Knittle, Robert 08-27-2020 (00:01:16)** 30:1 Board? 30:2 A. There was a group called the Administrators 30:3 In Medicine. 30:4 Q. Okay. 30:5 A. And that is a -- the medical directors -- 30:6 or the directors of the medical boards across the 30:7 country, and it was just kind of a subgroup that 30:8 was distinct, at least, from a -- from a nonprofit 30:9 standpoint. 30:10 Q. For the Administrators in Medicine, was 30:11 there anything involving controlled substances, 30:12 education or training? 30:13 A. I think there was always discussion about 30:14 it. There was nothing that was independently 30:15 developed by that group. 30:16 Q. And what would be discussed about it? 30:17 A. The number -- or I guess the outright 30:18 concern of the number of deaths that were being 30:19 caused by opioids and what the role would be of 30:20 legitimate drugs in the deaths of those people. 30:21 Q. Okay. And what was discussed about the 30:22 role of the legitimate drugs? 30:23 A. Well, generally, the boards of medicine 30:24 deal with physicians and the licensing and	VM31.8
31:01 - 31:04	**Knittle, Robert 08-27-2020 (00:00:17)** 31:1 disciplining of physicians, so we were looking at	VM31.9

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	31:2 things in terms of education for physicians, 31:3 awareness of the -- of the dangers of using 31:4 opioids.	
31:10 - 31:15	**Knittle, Robert 08-27-2020 (00:00:21)** 31:10 Q. Any other professional associations during 31:11 your time at the Board? 31:12 A. I don't believe so. I sat on the initial 31:13 board for the -- for the general licensing of 31:14 physicians across the state -- or across the 31:15 country.	VM31.10
32:09 - 32:18	**Knittle, Robert 08-27-2020 (00:00:28)** 32:9 Q. Okay. A little bit ago, you were talking 32:10 about when you were at the Board, you were 32:11 concerned with the licensing and discipline of 32:12 physicians. Was that kind of the main purpose of 32:13 the Board of Medicine? 32:14 A. Yeah, the main purpose is to protect the 32:15 public. And the way that the Board is structured 32:16 legally is for the licensing and disciplining of 32:17 physicians, which would include physician 32:18 assistants as well.	VM31.11
33:16 - 33:24	**Knittle, Robert 08-27-2020 (00:00:37)** 33:16 Q. Okay. Can you give me just a rundown of 33:17 what your duties were as executive director at the 33:18 Board? 33:19 A. Basically to carry out the wishes of the -- 33:20 of the Board of Medicine, to oversee the staff 33:21 during that implementation, and to maintain a 33:22 physical presence as well as to be available to the 33:23 legislative body and other groups on behalf of the 33:24 Board of Medicine.	VM31.12
37:24 - 38:08	**Knittle, Robert 08-27-2020 (00:00:32)** 37:24 Q. And how many licensees did the Board 38:1 oversee generally when you were there? 38:2 A. I'm trying to think. Around 3000. 38:3 Q. And that would include all three 38:4 specialties? 38:5 A. I think there were about 800 P.A.'s and 38:6 there were several hundred - but it was declining - 38:7 of podiatrists. I think there was around 3000 or	VM31.13

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	38:8 3200 physicians.	
39:07 - 40:09	**Knittle, Robert 08-27-2020 (00:01:17)**	VM31.14
	39:7 Q. We were talking about the DEA registration 39:8 or license. Do you understand why a doctor would 39:9 need a DEA registration or license before 39:10 prescribing a controlled substance? 39:11 A. I believe it's to try to appropriately 39:12 monitor them across the country. 39:13 Q. And a prescription for an opioid that's 39:14 written by a Board licensee must be for a 39:15 legitimate medical purpose. Correct? 39:16 A. Yes. 39:17 Q. And you agree with me that prescription 39:18 opioids can serve a legitimate medical purpose, 39:19 correct? 39:20 A. They can, yes. 39:21 Q. That patients can benefit from the use of 39:22 opioids being prescribed for a legitimate medical 39:23 purpose, correct? 39:24 A. Yes. 40:1 Q. Okay. And you agree that it could -- can 40:2 be appropriate for pharmacists to fill a 40:3 prescription for opioids for a patient, correct? 40:4 A. I believe that's their role, yes. 40:5 Q. Yes. And it's the physician that makes the 40:6 ultimate decision whether or not to prescribe an 40:7 opioid for a legitimate medical purpose to their 40:8 patient, correct? 40:9 A. That's correct.	
40:10 - 40:24	**Knittle, Robert 08-27-2020 (00:00:44)**	VM31.15
	40:10 Q. And does a prescriber need to consider a 40:11 patient's history prior to prescribing an opioid? 40:12 A. I believe they do. 40:13 Q. How about their diagnosis? 40:14 A. Yes. That would be, in part, determined by 40:15 the physician. 40:16 Q. Okay. Anything else that a prescriber 40:17 needs to consider when prescribing an opioid that 40:18 you know of? 40:19 A. No. Again, not being a physician, I can't	

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	40:20 get real specific as to exactly how diagnoses and 40:21 prescribing are specifically determined by a 40:22 physician to a patient. 40:23 Q. Okay. Should anybody be second-guessing 40:24 the physician's decision to prescribe an opioid?	
41:01 - 41:24	**Knittle, Robert 08-27-2020 (00:01:25)** 41:1 A. Some people will go for a second opinion. 41:2 Q. Okay. Other than a patient going for a 41:3 second opinion, is there anybody that should be 41:4 questioning a physician's decision to prescribe an 41:5 opioid to his or her patient? 41:6 A. I think if someone has concerns over it 41:7 that, you know, that's why the Board of Medicine is 41:8 there, for one aspect. But there are a number of 41:9 different controls throughout the system for 41:10 different aspects of the system. 41:11 We don't live in a perfect world, and 41:12 you know, some people will take advantage of things 41:13 for financial gain or -- in some respects for 41:14 physicians, for sexual gain. 41:15 But mostly, it's -- from what we've 41:16 seen, it's been monetary. 41:17 Q. And what do you mean that they will take 41:18 advantage for financial gain? What will they do? 41:19 A. They will overprescribe. 41:20 They will ask for kickbacks, knowing 41:21 that a patient would, you know, sell them, and they 41:22 wanted a portion of it. 41:23 Or to get part of the pills back 41:24 themselves.	VM31.16
42:01 - 42:24	**Knittle, Robert 08-27-2020 (00:01:08)** 42:1 Q. When you say they ask for kickbacks, are 42:2 they asking for kickbacks from the patient 42:3 themselves? 42:4 A. Yes. 42:5 Q. Okay. Can you explain that a little more 42:6 to me. 42:7 A. No, I think there have been instances where 42:8 someone would, you know, cash -- or fill the 42:9 prescription, sell the medications and give a	VM31.17

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	42:10 portion of the money back to the physician. 42:11 Q. Okay. And you -- during your tenure at the 42:12 Board, you have seen instances where physicians 42:13 were writing prescriptions for controlled 42:14 substances for sexual favors? 42:15 A. Yes. 42:16 Q. Okay. You said that there are certain 42:17 controls in the system. Besides the Board of 42:18 Medicine, what other controls are there in the 42:19 system? 42:20 A. Well, things like the DEA -- 42:21 Q. Okay. 42:22 A. -- who monitor how they're distributed and 42:23 who's distributing them. I think from the Board of 42:24 Pharmacy side and from the national side, I know	
43:01 - 43:24	**Knittle, Robert 08-27-2020 (00:01:09)** 43:1 that there are particular controls as to monitoring 43:2 of all sorts of the different types of controlled 43:3 substances or drugs or prescribed drugs. 43:4 But they monitor where they're going, 43:5 how much is going, those sorts of things. 43:6 Q. You said the DEA monitors how they are 43:7 distributed and who distributes them. Do you know 43:8 who distributes them? 43:9 A. No. 43:10 Q. Okay. Do you know how they are 43:11 distributed? 43:12 A. Not specifically. We -- our focus was, you 43:13 know, those sorts of things had always been beyond 43:14 the purview of the Board of Medicine, and even if 43:15 we were curious about something, there's -- there 43:16 were times that we just didn't have access to that 43:17 type of information. 43:18 Q. Were there times that you tried to gain 43:19 access to that type of information? 43:20 A. Not specifically, no. Unless it was very 43:21 specifically related to a particular case of a 43:22 physician or P.A. -- 43:23 Q. Okay. 43:24 A. -- or podiatrist.	VM31.18

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44:01 - 44:08	**Knittle, Robert 08-27-2020 (00:00:37)** 44:1 Q. Did the Board of Medicine while you were 44:2 there work with the DEA? 44:3 A. Yes, on individual cases. 44:4 Q. As you sit here today, can you identify an 44:5 instance where a person overdosed on a controlled 44:6 substance that they were taking as it was 44:7 prescribed to them by their physician? 44:8 A. No. Not after -- not after years, I can't.	VM31.19
44:09 - 44:21	**Knittle, Robert 08-27-2020 (00:00:32)** 44:9 Q. Is it something that you think has 44:10 happened? 44:11 A. As prescribed? 44:12 Q. Yes. 44:13 A. It's very possible that it did. 44:14 Q. You just, as you sit here today, can't 44:15 think of an instance? 44:16 A. No, it's -- but you know, there have been 44:17 instances of inappropriate prescribing where 44:18 perhaps they prescribed a higher dose than was 44:19 necessary. 44:20 Those would be particularly rare. But 44:21 I imagine that anything is possible.	VM31.20
44:22 - 45:07	**Knittle, Robert 08-27-2020 (00:00:31)** 44:22 Q. Okay. Do you know of an instance where a 44:23 drug distributor asked a physician to write a 44:24 prescription for a controlled substance? 45:1 A. Not specifically, no. 45:2 Q. Okay. When you say, "not specifically," do 45:3 you think there is an instance and you just can't 45:4 remember it, or -- 45:5 A. No, I don't think there was anything within 45:6 the Board of Medicine that I can remember a 45:7 specific complaint of that nature.	VM31.21
52:20 - 53:08	**Knittle, Robert 08-27-2020 (00:00:44)** 52:20 Q. So in most or all of the overprescribing 52:21 cases, the Board would get an expert to determine 52:22 whether or not the physician had been 52:23 overprescribing? 52:24 A. Yes. I think after probable cause is	VM31.22

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	53:1 found, some physicians will settle the case, will 53:2 go on for, you know, medical education or something 53:3 like that. 53:4 Others will -- are more adamant about 53:5 their own innocence in the matter, and those will 53:6 -- are the ones that we will get, you know, a -- an 53:7 expert for testimony at a hearing, administrative 53:8 hearing.	
53:23 - 54:11	**Knittle, Robert 08-27-2020 (00:00:31)** 53:23 Q. And you talked about the administrative 53:24 hearing. Who oversees an administrative hearing? 54:1 A. An administrative judge. 54:2 Q. Okay. And does that administrative judge 54:3 then make a recommendation to the Board? Or do 54:4 they make a ruling? 54:5 A. Yeah, they make a -- they make a ruling 54:6 that would be taken to the Board for a 54:7 determination, and the Board can either accept it, 54:8 reject it or modify it. 54:9 Q. Okay. So the Board makes the ultimate 54:10 decision on discipline. 54:11 A. They do.	VM31.23
57:01 - 57:24	**Knittle, Robert 08-27-2020 (00:01:22)** 57:1 11:14 a.m. We are on the record. 57:2 BY MS. ZERRUSEN: 57:3 Q. Mr. Knittle, earlier we were talking about 57:4 overprescribing. And I take it from your testimony 57:5 that there were licensees of the Board that 57:6 overprescribed; is that correct? 57:7 A. Yeah, there have been physicians that have 57:8 been disciplined for inappropriate prescribing. 57:9 Q. And when is the first time that you can 57:10 recall a licensee was disciplined for inappropriate 57:11 or overprescribing? 57:12 A. I don't know the specific instance. I 57:13 mean, they have been disciplining physicians for 57:14 that for decades prior to me being there. 57:15 Q. Okay. And was every licensee that the 57:16 Board investigated and found had overprescribed, 57:17 was every one of them disciplined?	VM31.24

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	57:18 A. To some degree. If there's, you know, an 57:19 abundance of evidence. 57:20 Q. And earlier we talked about diversion. Is 57:21 overprescribing diversion? 57:22 A. Not necessarily. 57:23 Q. Okay. 57:24 A. It could -- it could lend itself to	
58:01 - 58:21	**Knittle, Robert 08-27-2020 (00:01:11)** 58:1 diversion, but -- 58:2 Q. So the overprescribing itself is not 58:3 diversion, it's what the patient then does with 58:4 those pills that they were overprescribed? 58:5 A. That would be determined by the intent of 58:6 the physician. 58:7 Q. Okay. 58:8 A. If they're in collaboration, it could be 58:9 diversion, yes. 58:10 Q. And did -- during your tenure at the Board, 58:11 did that happen where physicians were in 58:12 collaboration with their patient to overprescribe? 58:13 A. I think there have been some instances of 58:14 it, but I can't be specific. 58:15 Q. Okay. Would those physicians have been 58:16 disciplined? 58:17 A. Yes. 58:18 Q. Would you agree with me that diversion is 58:19 illegal? 58:20 A. Yes. I believe so. Either from an 58:21 administrative or criminal standpoint or both.	VM31.25
59:17 - 59:24	**Knittle, Robert 08-27-2020 (00:00:29)** 59:17 Q. Okay. Were there any other things that 59:18 licensees of the Board did related to opioids that 59:19 they were disciplined for? 59:20 A. Perhaps their use of them themselves 59:21 personally. 59:22 Q. And would those licensees have been 59:23 disciplined? 59:24 A. They could be disciplined, but they --	VM31.26
60:01 - 60:24	**Knittle, Robert 08-27-2020 (00:01:34)** 60:1 generally, they were in a point of probably	VM31.27

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	60:2 addiction themselves and it would be specific as to 60:3 whether they were impaired at the time that they 60:4 were practicing as well as whether they were using 60:5 inappropriately. 60:6 Q. Did the Board work with licensees that were 60:7 addicted themselves to get them treatment? 60:8 A. Yes, we did. In fact, I think one of the 60:9 first things that we were able to pass when I came 60:10 on as the executive director was establishment of a 60:11 physicians health program in West Virginia. 60:12 Q. And what's the physicians health program? 60:13 A. It's the program that works with physicians 60:14 that have alcohol or drug abuse or addiction 60:15 issues, and to some degree, mental illness. 60:16 Q. And why do physicians need a specific 60:17 program for themselves? 60:18 A. I think just because of the seriousness of 60:19 the situation with them that physicians - or 60:20 anybody that's involved with drugs - can do a 60:21 tremendous amount of damage if they're not on top 60:22 of their -- of their game. 60:23 Q. Okay. And did the Board work with the 60:24 physicians health program?	
61:01 - 61:08	**Knittle, Robert 08-27-2020 (00:00:21)** 61:1 A. Yes. 61:2 Q. Okay. And how did they collaborate? How 61:3 did the two agencies collaborate? 61:4 A. There's a -- there's an agreement between 61:5 the Board of Medicine and the physicians health 61:6 program as well as specific legislature in 61:7 establishing it, that put together the guidelines 61:8 as to how we worked.	VM31.28
61:09 - 61:12	**Knittle, Robert 08-27-2020 (00:00:12)** 61:9 Q. And what was the agreement between -- 61:10 between the two? 61:11 A. It was a -- it was a matter of mutually 61:12 sharing information under proper circumstances.	VM31.29
62:04 - 62:08	**Knittle, Robert 08-27-2020 (00:00:15)** 62:4 Q. Okay. Was the physicians health program 62:5 successful in treating addiction?	VM31.30

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	62:6 A. Yes. And in fact, the model that we 62:7 established in West Virginia has been emulated 62:8 across the country by a number of different states.	
62:09 - 62:10	**Knittle, Robert 08-27-2020 (00:00:05)** 62:9 Q. So addiction can be treated. 62:10 A. Yes, it can.	VM31.31
63:04 - 63:08	**Knittle, Robert 08-27-2020 (00:00:14)** 63:4 Q. Okay. During your tenure at the Board, 63:5 were licensees required to take continuing 63:6 education related to pain management? 63:7 A. They were required to do continuing 63:8 education, yes.	VM31.32
65:17 - 66:09	**Knittle, Robert 08-27-2020 (00:00:56)** 65:17 Q. Do you recall this requirement for the 65:18 licensees to take two hours of continuing education 65:19 on end-of-life care, including pain management? 65:20 A. Yes, I do. And the emphasis there was -- 65:21 was on the end-of-life care. 65:22 Q. Okay. And why was the emphasis on 65:23 end-of-life care? 65:24 A. Just in order for people to be able to not 66:1 go through any unnecessary pain in terminal illness 66:2 cases. 66:3 Q. Was this always a requirement, a continuing 66:4 education requirement, while you were at the Board? 66:5 A. Yeah, I believe it was there before I 66:6 started. 66:7 Q. Okay. Was it there when you -- through 66:8 when you left? 66:9 A. To my recollection, yes.	VM31.33
70:09 - 70:24	**Knittle, Robert 08-27-2020 (00:00:58)** 70:9 Q. Earlier when we were talking about the 70:10 disciplinary process, I believe you said that there 70:11 were two investigators employed by the Board? 70:12 A. Yeah, for years we only had one. 70:13 Q. Okay. 70:14 A. But with the amount of -- of complaints and 70:15 the complexity of the inappropriate prescribing 70:16 cases that were coming up, then it was necessary to 70:17 hire a second investigator.	VM31.34

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	70:18 Q. And do you recall what year that was? 70:19 A. You know, I wish I did, but I don't. 70:20 Q. Why were inappropriate prescribing cases 70:21 complex? 70:22 A. Because I think you eventually have to 70:23 establish that the prescribing itself was 70:24 inappropriate, so you needed to get all the	
71:01 - 71:11	**Knittle, Robert 08-27-2020 (00:00:38)** 71:1 records, all of the prescription records, and put 71:2 them together in a meaningful way in order to try 71:3 to make a determination of that. 71:4 So it's a very tedious process in 71:5 order to do it. 71:6 Q. Okay. I'm assuming - which is probably not 71:7 good to do during a deposition - that based on your 71:8 testimony, the amount of inappropriate prescribing 71:9 cases increased during your -- over your tenure at 71:10 the Board. Is that correct? 71:11 A. It did.	VM31.35
74:20 - 74:24	**Knittle, Robert 08-27-2020 (00:00:29)** 74:20 Q. Do you recall if -- if the opioid-related 74:21 cases were concentrated in a particular geographic 74:22 area of West Virginia? 74:23 A. They were more southern than they were 74:24 northern. Huntington, Wayne County, Mingo, down	VM31.36
75:01 - 75:07	**Knittle, Robert 08-27-2020 (00:00:21)** 75:1 towards the Beckley area. We had a number of cases 75:2 through there, as well as around the Charleston 75:3 area. 75:4 That is not to say that there were not 75:5 cases in the Eastern Panhandle or Morgantown area, 75:6 but there were quite a few in the southern part of 75:7 the state.	VM31.37
75:08 - 75:12	**Knittle, Robert 08-27-2020 (00:00:26)** 75:8 Q. Do you have any idea why? 75:9 A. No. I don't. There's a lot of different 75:10 theories that the people cast about as to issues of 75:11 addiction in Appalachia. But I don't have a 75:12 specific one.	VM31.38
76:19 - 77:01	**Knittle, Robert 08-27-2020 (00:00:19)**	VM31.39

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	76:19 Q. Did the investigators have the ability to 76:20 look at the West Virginia Controlled Substances 76:21 Monitoring Program? 76:22 A. I believe that they did. 76:23 Q. Okay. And if I call it "the CSMP," will 76:24 you understand that it's the West Virginia 77:1 Controlled Substances Monitoring Program?	
77:02 - 77:13	**Knittle, Robert 08-27-2020 (00:00:43)** 77:2 A. Yeah. I don't think that was always in 77:3 existence. 77:4 Q. Okay. 77:5 A. And it came on to -- towards the latter 77:6 part of my tenure with the Board. 77:7 Q. Do you know why the CSMP was implemented? 77:8 A. I think to try to get a better handle on 77:9 what was being distributed and supplied and 77:10 distributed to physicians and patients then. 77:11 Q. Do you know what the -- what information 77:12 the CSMP contains? 77:13 A. I can't specifically recall.	VM31.40
77:14 - 77:24	**Knittle, Robert 08-27-2020 (00:00:40)** 77:14 Q. Okay. Do you know who maintains the CSMP? 77:15 A. It had been the Board of Pharmacy, if it's 77:16 still there. 77:17 Q. Okay. Prior to the CSMP, what would the 77:18 investigators look at to try to get information 77:19 regarding dosages and prescribing of physicians? 77:20 A. It would be a subpoena of medical records 77:21 of a physician or particular patients. 77:22 Q. Was the CSMP a helpful tool then once it 77:23 came about? 77:24 A. I believe it was helpful.	VM31.41
78:19 - 78:22	**Knittle, Robert 08-27-2020 (00:00:16)** 78:19 Q. Do you know if prescribers of controlled 78:20 substances were required to register with the CSMP? 78:21 A. I think they were. I thought that was a 78:22 change in -- in law from the Board of Pharmacy.	VM31.42
79:01 - 79:24	**Knittle, Robert 08-27-2020 (00:02:03)** 79:1 Q. All right. Can you pull out Tab 14? 79:2 COURT REPORTER: Sandy, will this be	VM31.43

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	79:3 Exhibit 3?	
	79:4 KNITTLE DEPOSITION EXHIBIT NO. 3	
	79:5 (WVBOM Quarterly Newsletter, Volume	
	79:6 14, Issue 1, January-March 2010 was	
	79:7 marked for identification purposes as	
	79:8 Knittle Deposition Exhibit No. 3.)	
	79:9 A. You guys like our newsletters, huh?	
	79:10 Q. I tried to get other stuff. This is all I	
	79:11 got. All right. So this is going to be marked as	
	79:12 Exhibit 3 to your deposition. It is the West	
	79:13 Virginia Board of Medicine Quarterly Newsletter,	
	79:14 Volume 14, Issue 1, January through March 2010.	
	79:15 And if you look near the bottom of the	
	79:16 page, it discusses the committee substitute for	
	79:17 Senate Bill 365 and Senate Bill 514. You want to	
	79:18 take a minute and read those two paragraphs?	
	79:19 A. Okay.	
	79:20 Q. All right. So for Senate Bill 365, it says	
	79:21 that by at least July 1st, 2011, prescribers of	
	79:22 controlled substances must have access to the CSMP.	
	79:23 Correct?	
	79:24 A. Yes.	
80:17 - 80:21	**Knittle, Robert 08-27-2020 (00:00:14)**	VM31.44
	80:17 Q. So if a physician had -- was checking the	
	80:18 CSMP, they'd be able to see if their patient had	
	80:19 been going from doctor to doctor to doctor to try	
	80:20 to get different controlled substances, right?	
	80:21 A. Correct.	
81:04 - 81:11	**Knittle, Robert 08-27-2020 (00:00:28)**	VM31.45
	81:4 Q. Okay. It also says that Senate Bill 365	
	81:5 "limits liability of practitioners for good faith	
	81:6 reliance on the" CSMP database. Do you know what	
	81:7 the purpose of limiting the liability of the	
	81:8 practitioners was?	
	81:9 A. Well, the first response is it would be to	
	81:10 curb malpractice cases against them if they were	
	81:11 prescribing opioids.	
82:15 - 82:24	**Knittle, Robert 08-27-2020 (00:00:36)**	VM31.46
	82:15 Q. Okay. If you go -- the Senate Bill 514, it	
	82:16 says, "controlled substance reporting when a	

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	82:17 prescription is filled for a controlled substance 82:18 or a controlled substance is dispensed." 82:19 A. Yes. 82:20 Q. The only information that is then reported 82:21 to the CSMP would be when a controlled substance is 82:22 filled or dispensed by a pharmacy or a doctor that 82:23 dispenses it out of their office? Is that right? 82:24 A. Yes.	
85:16 - 85:19	**Knittle, Robert 08-27-2020 (00:00:09)** 85:16 Q. And in fact, it would be helpful for 85:17 physicians to check the CSMP prior to writing a 85:18 prescription for an opioid, right? 85:19 A. Yes.	VM31.47
85:20 - 86:02	**Knittle, Robert 08-27-2020 (00:00:24)** 85:20 Q. And what should the prescriber be looking 85:21 for when they check the CSMP? 85:22 A. Well, apparently -- if it was a physician, 85:23 then you would be looking at a particular patient 85:24 to see if they had been to five different 86:1 physicians over a certain period of time looking 86:2 for a particular type of drug or treatment.	VM31.48
88:01 - 88:06	**Knittle, Robert 08-27-2020 (00:00:18)** 88:1 Q. Okay. If a doctor was being investigated 88:2 for inappropriate or overprescribing, would their 88:3 license or their ability to prescribe be put on 88:4 hold in any sort of way during the investigative 88:5 process? 88:6 A. Generally not.	VM31.49
88:07 - 88:21	**Knittle, Robert 08-27-2020 (00:00:37)** 88:7 Q. Okay. 88:8 A. If it was a case where it was -- it was 88:9 extremely severe, that you had an overdose of -- 88:10 deaths of five people because of prescribing, 88:11 sometimes there's a legal means in order to, you 88:12 know, suspend someone on an emergency basis and 88:13 have a quick hearing. 88:14 That was extremely rare -- 88:15 Q. Okay. 88:16 A. -- for that -- for that to happen. 88:17 Q. Do you recall --	VM31.50

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	88:18 A. So -- 88:19 Q. Sorry. 88:20 A. -- until probable cause is found, people 88:21 are able to practice.	
88:22 - 89:01	**Knittle, Robert 08-27-2020 (00:00:12)** 88:22 Q. Do you recall an instance where there were 88:23 deaths of several people that somebody's ability to 88:24 prescribe was almost immediately revoked? 89:1 A. No.	VM31.51
89:02 - 89:06	**Knittle, Robert 08-27-2020 (00:00:12)** 89:2 Q. Okay. But it is an option for the Board to 89:3 immediately revoke somebody's ability to prescribe 89:4 or practice medicine. 89:5 A. There is that -- there is that aspect in an 89:6 immediate situation.	VM31.52
89:12 - 89:22	**Knittle, Robert 08-27-2020 (00:00:41)** 89:12 Q. What types of discipline could be doled out 89:13 to a physician? Starting with the harshest penalty 89:14 to the lightest penalty. 89:15 A. Well, you could permanently lose your 89:16 license, would probably be the harshest. You know, 89:17 probably the least severe would be some type of 89:18 continuing medical education. 89:19 Sometimes community service. But that 89:20 was rarely used. 89:21 Q. Could somebody's license be suspended? 89:22 A. Yes, that's in the middle.	VM31.53
93:15 - 94:03	**Knittle, Robert 08-27-2020 (00:00:41)** 93:15 Q. Do you know what the "epidemic of 93:16 prescription drug fraud" is? 93:17 A. I think that's what we were talking about, 93:18 where people would alter prescriptions or steal 93:19 prescription pads. 93:20 Q. Okay. Do you know how long this epidemic 93:21 lasted? 93:22 A. No. But given how quickly the legislative 93:23 acts, it was probably a number of years. 93:24 Q. Are you saying that they -- they don't act 94:1 that quickly? 94:2 A. No, they -- they usually take their time on	VM31.54

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	94:3 these things.	
94:04 - 94:07	**Knittle, Robert 08-27-2020 (00:00:07)**	VM31.55
	94:4 Q. Okay. 94:5 A. Until it comes to their attention to a 94:6 strong enough point where it becomes legislatively 94:7 necessary.	
101:24 - 101:24	**Knittle, Robert 08-27-2020 (00:00:03)**	VM31.56
	101:24 Q. Was there a time when the standard of care	
102:01 - 102:24	**Knittle, Robert 08-27-2020 (00:01:33)**	VM31.57
	102:1 was to treat with opioids? 102:2 A. I think it was professed by some people to 102:3 do that, that narcotics was the thing that you 102:4 should start out with first and foremost. 102:5 And there were some physicians that 102:6 prescribed to that approach. But it was not 102:7 generally very effective and as the addictions rose 102:8 and the deaths rose, it was really called into 102:9 question. 102:10 Q. You said it was professed by people. Do 102:11 you know who professed it? 102:12 A. I think some of the pharmaceutical 102:13 manufacturers had pushed for it pretty heavily. 102:14 Q. Do you know what the Joint Commission on 102:15 the Accreditation of Hospitals is? 102:16 A. I'm aware of what -- that that entity 102:17 exists, yes. 102:18 Q. Okay. Do you know what they do? 102:19 A. They accredit hospitals as to appropriate 102:20 means of patient care, safety, medical treatment. 102:21 Q. Do you remember guidance from the Joint 102:22 Commission that pain should be treated as the fifth 102:23 vital sign? 102:24 A. I don't know if they adopted that or --	
103:01 - 103:24	**Knittle, Robert 08-27-2020 (00:01:41)**	VM31.58
	103:1 actually, I think it was a pharmacy that started 103:2 that, and people were led to believe that that was 103:3 truly a medical basis when in fact it wasn't. 103:4 It was more of a marketing scheme. 103:5 Q. Did pain being seen as the fifth vital sign 103:6 change the way that physicians prescribed pain	

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103:7 medication?
103:8 A. I don't think it ever came up a great deal
103:9 in our complaint process as to whether they fell
103:10 back to that as a line of defense.
103:11 Q. What did come up in the complaint process
103:12 as a line of defense for inappropriate prescribing?
103:13 A. On which case? There's --
103:14 Q. Was there an excuse or something that
103:15 people used regularly?
103:16 A. You know, some people were -- and there was
103:17 a very select few physicians who adamantly believed
103:18 that narcotics was the first and only treatment.
103:19 But that standard of care caused a
103:20 tremendous amount of addiction and deaths when you
103:21 look back on those particular cases.
103:22 You know, others -- there was a whole
103:23 range of -- of rationale as to why they did what
103:24 they did.

104:01 - 104:24 **Knittle, Robert 08-27-2020 (00:01:19)** VM31.59

104:1 Q. You just said, "that standard of care
104:2 caused a tremendous amount of addiction and
104:3 deaths."
104:4 A. Yes.
104:5 Q. What about standard of care caused
104:6 addiction and deaths?
104:7 A. If someone actually believed that the only
104:8 way to deal with any kind of pain was high dosages
104:9 of opioids, then the end result for people is that
104:10 they would become addicted, you know, a vast
104:11 majority of the time, and would abuse the drug,
104:12 seek other ways to get it or get their dosages
104:13 increased by that physician.
104:14 And a number of times, if they mixed
104:15 it with alcohol or whatever, they died.
104:16 Q. And that was a problem with some of the
104:17 Board's licensees, that they -- that was their view
104:18 of the standard of care?
104:19 A. Yes.
104:20 Q. Okay. How -- how would the Board know
104:21 about physicians that believed this kind of

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	104:22 standard of care?	
	104:23 A. Their own testimony.	
	104:24 Q. Okay. Other than receiving a complaint,	
105:01 - 105:04	**Knittle, Robert 08-27-2020 (00:00:12)**	VM31.60
	105:1 would the Board be able to investigate a doctor	
	105:2 regarding the standard of care?	
	105:3 A. No. The Board doesn't have the capacity to	
	105:4 initiate their own complaints.	
106:02 - 106:14	**Knittle, Robert 08-27-2020 (00:00:43)**	VM31.61
	106:2 Q. So Mr. Knittle, could you define for me,	
	106:3 when we've just been talking about standard of	
	106:4 care, what is your definition of "standard of	
	106:5 care?"	
	106:6 A. I think it's an approach by a particular	
	106:7 physician as to what he feels is the best way to	
	106:8 manage a medical issue.	
	106:9 Q. Okay. And when you say the standard of	
	106:10 care caused addictions and deaths, what do you mean	
	106:11 by "standard of care" in that statement?	
	106:12 A. That some physicians had believed that the	
	106:13 best way to treat pain was for high and consistent	
	106:14 amounts of opioids.	
107:04 - 108:01	**Knittle, Robert 08-27-2020 (00:01:09)**	VM31.62
	107:4 Did -- while you were at the Board,	
	107:5 did you recommend that physicians restrict their	
	107:6 patient to one pharmacy?	
	107:7 A. I think that was more from the Board of	
	107:8 Pharmacy than the Board of Medicine.	
	107:9 Q. Okay.	
	107:10 A. It was a way to try to curtail people	
	107:11 trying to gain prescriptions from different	
	107:12 pharmacies. You know, some -- some people would	
	107:13 get a prescription from one doctor and go to one	
	107:14 pharmacy and then go to another doctor and then go	
	107:15 to another pharmacy.	
	107:16 Q. Okay. Was that a problem --	
	107:17 A. Yeah.	
	107:18 Q. -- in West Virginia?	
	107:19 A. It was.	
	107:20 Q. At any time, was this -- kind of go to a	

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	107:21 doctor, go to different pharmacies to fill 107:22 prescriptions. At any time did that stop or 107:23 lessen? Was there a time period -- 107:24 A. I think with the monitoring program, it 108:1 certainly helped. I think that would be curtailed.	
109:06 - 109:24	**Knittle, Robert 08-27-2020 (00:00:52)** 109:6 Q. Okay. At some point, were board -- or 109:7 sorry, were licensees of the Board required to 109:8 obtain CME credits related to the administration of 109:9 naloxone? 109:10 A. Naloxone? 109:11 Q. Yeah. 109:12 A. I think there was. 109:13 Q. Okay. Do you know why the Board would 109:14 require licensees to take CME credits related to 109:15 naloxone? 109:16 A. Just because of the amount of overdoses 109:17 that were occurring through the use of prescribed 109:18 medications and, later, nonprescribed medications 109:19 as well. 109:20 Q. So was the CME kind of training on the 109:21 administration of naloxone? 109:22 A. Yes. It -- which is a rather simple 109:23 procedure -- 109:24 Q. Okay.	VM31.63
110:01 - 110:08	**Knittle, Robert 08-27-2020 (00:00:19)** 110:1 A. -- for the administration of it. But they 110:2 should be aware of how to do it and that it's 110:3 available. 110:4 Q. Do you think that it would help reduce 110:5 opioid overdoses if physicians were trained in the 110:6 administration of naloxone? 110:7 A. I think with the -- with the use of 110:8 naloxone, it was to prevent deaths.	VM31.64
110:22 - 111:06	**Knittle, Robert 08-27-2020 (00:00:30)** 110:22 Q. Was -- during your time at the Board, was 110:23 it entirely self-funded? 110:24 A. Yes. We -- it's just basically license 111:1 fees. And that's -- that's it. 111:2 Q. And renewal fees?	VM31.65

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	111:3 A. Yes. But the fines, you know, go to the 111:4 general fund. The Board of Medicine does not gen 111:5 -- benefit from the fines that they impose on 111:6 people.	
111:09 - 111:15	**Knittle, Robert 08-27-2020 (00:00:13)** 111:9 Q. So the Board of Medicine -- excuse me -- 111:10 does not receive any money from the City of 111:11 Huntington, correct? 111:12 A. Correct. 111:13 Q. And the Board of Medicine does not receive 111:14 any money from Cabell County, correct? 111:15 A. Correct.	VM31.66
112:04 - 112:24	**Knittle, Robert 08-27-2020 (00:01:15)** 112:4 Q. Earlier when we were discussing the paper 112:5 that had been republished in the newsletter, it 112:6 talked about an opioid epidemic. Do you believe 112:7 that West Virginia had an opioid epidemic? 112:8 A. Yes, I do. 112:9 Q. Do you know when it began? 112:10 A. I think it began probably in the mid '90s. 112:11 They used to refer to it as "hillbilly heroin," the 112:12 use of oxycodone and OxyContin. And it just began 112:13 -- it just continued to increase since then. 112:14 Q. Do you believe West Virginia still has an 112:15 opioid epidemic? 112:16 A. I couldn't say. I have not kept track of 112:17 the records. I no longer live in West Virginia, 112:18 so, you know, I've had little to no contact with 112:19 the Board of Medicine since I left. 112:20 Q. Did West Virginia have an opioid epidemic 112:21 in 2016 when you were still at the Board? 112:22 A. Yes. 112:23 Q. Do you believe that Cabell County had an 112:24 opioid epidemic?	VM31.67
113:01 - 113:24	**Knittle, Robert 08-27-2020 (00:01:32)** 113:1 A. Yes, I do. 113:2 Q. Do you know when that began? 113:3 A. No. I think along with other portions of 113:4 the state, it just increased and increased. I know 113:5 that Wayne County had some real marked issues years	VM31.68

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	113:6 prior to 2016. 113:7 Q. Do you believe that the City of Huntington 113:8 had an opioid epidemic? 113:9 A. I believe their citizens did, yes. 113:10 Q. Do you believe that inappropriate 113:11 prescribing contributed to the opioid epidemic? 113:12 A. I think in part, yes. 113:13 Q. Do you believe that doctor shopping 113:14 contributed to the opioid epidemic? 113:15 A. Yes. 113:16 Q. Do you believe that drug cartels 113:17 contributed to the opioid epidemic? 113:18 A. Define "cartel." 113:19 Q. You were talking about the oversea 113:20 drug-related -- 113:21 A. No. No, I don't think from a criminal 113:22 standpoint. There was not -- I think there's some 113:23 -- some issue of crime involved with -- with any 113:24 addictive drug. But I don't think they were the	
114:01 - 114:19	**Knittle, Robert 08-27-2020 (00:01:07)** 114:1 main push for the -- for the epidemic. 114:2 Q. Okay. What do you think the main push for 114:3 the epidemic was? 114:4 A. I think the amount of addiction that 114:5 occurred through people gaining opioids through 114:6 whatever means they could. 114:7 Q. Including doctors prescribing it to them? 114:8 A. Yes. 114:9 Q. Do you think the Board of Medicine bears 114:10 any responsibility for the opioid epidemic? 114:11 A. No. I don't think the Board of Medicine 114:12 did. Our efforts were to try to protect the public 114:13 and to provide education through the public and 114:14 physicians and to discipline those who were 114:15 inappropriately prescribing. 114:16 Q. So you believe that the Board did 114:17 everything that it could have. 114:18 A. I believe so, yeah. We tried hard. And 114:19 it's a -- it's a heart-wrenching concern.	VM31.69
115:21 - 116:04	**Knittle, Robert 08-27-2020 (00:00:30)**	VM31.70

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	115:21 epidemic. And earlier, we had talked about pain 115:22 being treated as a fifth vital sign. Do you 115:23 believe that that contributed to the opioid 115:24 epidemic? 116:1 A. I think in a -- in a sense that it gave 116:2 some -- oh, I'm trying to think of the proper word. 116:3 -- basis for physicians to prescribe 116:4 in the manner that some of them did.	
116:05 - 116:14	**Knittle, Robert 08-27-2020 (00:00:44)** 116:5 Q. And do you believe that that manner was 116:6 overprescribing? 116:7 A. Yes. I think it was initially. 116:8 Q. Okay. Did the Board of Medicine undertake 116:9 any opioid-related initiatives to help combat the 116:10 opioid epidemic in West Virginia? 116:11 A. I think there was a concern over it and we 116:12 took steps legislatively and through education and 116:13 through discipline -- disciplining physicians and 116:14 P.A.'s, podiatrists.	VM31.71
121:20 - 122:05	**Knittle, Robert 08-27-2020 (00:00:36)** 121:20 Q. Was the Board ever influenced by any drug 121:21 distributor to create a policy regarding the proper 121:22 use of opioids? 121:23 A. Not that I'm aware of, no. We had very 121:24 little contact with pharmaceutical -- as far as 122:1 pharmaceutical manufacturers. They would call us 122:2 now and then, offer us, you know, something that we 122:3 could download to say, "Don't use opioids 122:4 inappropriately" or something like that, but we had 122:5 very little contact with them whatsoever.	VM31.72
122:18 - 122:21	**Knittle, Robert 08-27-2020 (00:00:12)** 122:18 Q. Okay. So the drug distributors would not 122:19 have influenced the Board of Medicine to create 122:20 policies related to opioids. 122:21 A. No, I don't believe so.	VM31.73
123:09 - 124:14	**Knittle, Robert 08-27-2020 (00:02:38)** 123:9 Q. As you sit here today, do you know of an 123:10 instance where a wholesale drug distributor tried 123:11 to approach a physician to influence the Board? 123:12 A. I do not, no.	VM31.74

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123:13 Q. Okay. All right. Can you grab Tab 2?
123:14 KNITTLE DEPOSITION EXHIBIT NO. 7
123:15 (Management of Intractable Pain Act
123:16 passed March 14, 1998 was marked for
123:17 identification purposes as Knittle
123:18 Deposition Exhibit No. 7.)
123:19 A. Okay.
123:20 Q. All right. This will be marked as Exhibit
123:21 7 to your deposition, and it is the Management of
123:22 Intractable Pain which was passed March 14th, 1998.
123:23 Do you see that?
123:24 A. Yes, I do.
124:1 Q. Are you familiar with the Management of
124:2 Intractable Pain Act?
124:3 A. I had been, yes.
124:4 Q. Okay. You go down to near the bottom.
124:5 It's bold print, Section 30-3A-2, "Limitation on
124:6 disciplinary sanctions or criminal punishment
124:7 related to management of intractable pain."
124:8 If you just want to read that Section
124:9 A-1 and 2.
124:10 A. Okay.
124:11 Q. And so this is saying that the Board of
124:12 Medicine could not discipline any licensees in the
124:13 instances described in Section A-1 and 2. Correct?
124:14 A. Yes.

125:22 - 126:15 **Knittle, Robert 08-27-2020 (00:01:12)** VM31.75

125:22 Q. Okay. All right. If you want to grab Tab
125:23 3.
125:24 KNITTLE DEPOSITION EXHIBIT NO. 8
126:1 (Joint Policy Statement on Pain
126:2 Management at the End of Life was
126:3 marked for identification purposes as
126:4 Knittle Deposition Exhibit No. 8.)
126:5 A. Okay.
126:6 Q. All right. This is going to be marked as
126:7 Exhibit 8 to your deposition. It is the Joint
126:8 Policy Statement on Pain Management at the End of
126:9 Life. And if you turn to the last page, it says
126:10 that it was approved by the West Virginia Board of

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	126:11 Medicine March 12, 2001. 126:12 A. Yes. 126:13 Q. Are you aware of the Joint Policy Statement 126:14 on Pain Management at the End of Life? 126:15 A. Yes, I was aware of it.	
126:16 - 126:24	**Knittle, Robert 08-27-2020 (00:00:30)** 126:16 Q. Okay. Do you know if the Board of Medicine 126:17 was involved in the drafting of this? 126:18 A. I do not. I imagine they had -- they 126:19 probably had it placed before them in order to 126:20 approve it, and, you know, they could have -- they 126:21 may have offered suggestions as to language and 126:22 things, but I don't have any -- any recollection of 126:23 that. It was before I was there. 126:24 Q. Okay. Do you know what the purpose of the	VM31.76
126:24 - 128:06	**Knittle, Robert 08-27-2020 (00:01:36)** 126:24 Q. Okay. Do you know what the purpose of the 127:1 Joint Policy Statement On Pain Management At The 127:2 End of Life was? 127:3 A. I think because -- in order to use opioids 127:4 for the use of intractable pain with terminal 127:5 patients, in order to have a little more dignity in 127:6 death without unnecessary pain and suffering. 127:7 Q. On page 3 -- 127:8 A. Okay. 127:9 Q. -- the first paragraph, which is very 127:10 similar to the Position Statement in the Management 127:11 Of Intractable Pain, it says, "Health care 127:12 professionals should not fear disciplinary action 127:13 from the Boards for prescribing, administering, or 127:14 dispensing controlled substances, including opioid 127:15 analgesics, for a legitimate medical purpose and in 127:16 the usual course of professional practice. 127:17 All such prescribing must be 127:18 established with clear documentation of unrelieved 127:19 pain and in compliance with applicable state or 127:20 federal law." 127:21 So again, like we've discussed, you -- 127:22 the healthcare professionals should not fear 127:23 disciplinary action for prescribing opioids.	VM31.77

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	127:24 Right? 128:1 A. As long as they follow standard of care. 128:2 Q. Yeah. Because opioids can serve a 128:3 legitimate medical purpose. 128:4 A. They can, yes. Particularly with end of 128:5 life when there's not an issue of addiction with 128:6 someone who's terminally ill.	
129:05 - 129:09	**Knittle, Robert 08-27-2020 (00:00:01)** 129:5 KNITTLE DEPOSITION EXHIBIT NO. 9 129:6 (Policy for the Use of Controlled 129:7 Substances for the Treatment of Pain 129:8 was marked for identification purposes 129:9 as Knittle Deposition Exhibit No. 9.)	**VM31.78**
129:23 - 130:07	**Knittle, Robert 08-27-2020 (00:00:30)** 129:23 Q. So then if you turn to the next page, it 129:24 says that this is "Policy for the Use of Controlled 130:1 Substances for the Treatment of Pain, Effective 130:2 January 10, 2005." 130:3 Do you know if this was a replacement 130:4 to the 1997 Position Statement on the use of 130:5 opioids that we discussed earlier that was Exhibit 130:6 6? 130:7 A. I believe that it was.	**VM31.79**
130:16 - 130:24	**Knittle, Robert 08-27-2020 (00:00:29)** 130:16 Q. And was this policy used then to establish 130:17 the standard of care for licensees to follow or 130:18 abide by? 130:19 A. Yes, I think it was -- it was written in 130:20 order to be given some guidelines to go by. 130:21 Q. And by this, the Board was leaving the 130:22 decision to manage pain to the discretion of the 130:23 treating physician. Correct? 130:24 A. Yes. Yes.	**VM31.80**
131:17 - 132:07	**Knittle, Robert 08-27-2020 (00:00:55)** 131:17 Q. Okay. And this policy was provided to 131:18 alleviate physician uncertainty and to encourage 131:19 better pain management, correct? 131:20 A. Yes. And I think, you know, in part too, 131:21 to curb the amount of use inappropriately of 131:22 opioids.	**VM31.81**

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	131:23 Q. And this policy has a paragraph, a last 131:24 paragraph, on page 1 very similar to the paragraphs 132:1 that we've read before about a physician shouldn't 132:2 fear disciplinary action from the Board? 132:3 So while it was the policy of the 132:4 Board in 1997, it continued to be the policy to 132:5 make sure its licensees didn't fear discipline for 132:6 just prescribing opioids, correct? 132:7 A. Correct.	
132:08 - 132:12	**Knittle, Robert 08-27-2020 (00:00:13)** 132:8 Q. Okay. And if a physician deviated from 132:9 this policy, they wouldn't automatically be 132:10 disciplined. Correct? 132:11 A. No. It would depend on the circumstances 132:12 of the patient.	VM31.82
132:13 - 132:20	**Knittle, Robert 08-27-2020 (00:00:21)** 132:13 Q. Okay. I know you were only there for a 132:14 couple of weeks. But was the Board influenced by 132:15 any wholesale drug distributors to create this 132:16 policy? 132:17 A. I'm not aware of any. 132:18 Q. Okay. Do you know if they were influenced 132:19 by any drug manufacturers to create this policy? 132:20 A. I'm not aware of any.	VM31.83
132:21 - 133:03	**Knittle, Robert 08-27-2020 (00:00:22)** 132:21 Q. Okay. How would the Board let its 132:22 licensees know about the changes in the policy? 132:23 A. Oftentimes through the newsletter. 132:24 Q. Okay. 133:1 A. And later on, through the website. And to 133:2 sharing with other entities that the physicians 133:3 come in contact with.	VM31.84
133:17 - 135:21	**Knittle, Robert 08-27-2020 (00:02:31)** 133:17 KNITTLE DEPOSITION EXHIBIT NO. 10 133:18 (WVBOM Quarterly Newsletter, Volume 133:19 12, Issue 4, October-December 2008 was 133:20 marked for identification purposes as 133:21 Knittle Deposition Exhibit No. 10.) 133:22 A. Okay. 133:23 Q. This will be marked as Exhibit 10 to your	VM31.85

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133:24 deposition. It's the West Virginia Board of
134:1 Medicine Quarterly Newsletter, Volume 12, Issue 4,
134:2 October through December of 2008. Correct?
134:3 A. Yes.
134:4 Q. Okay. Could you turn to page 6?
134:5 A. Okay.
134:6 Q. All right. The bottom part of the page
134:7 says, "Responsible Opioid Prescribing: A
134:8 Physician's Guide; Now Available For Online
134:9 Purchase."
134:10 And it says that "In the Spring of
134:11 2008, the Board of Medicine, in conjunction with
134:12 the Federation of State Medical Boards and the
134:13 Health and Human Services Committee on Substance
134:14 Abuse Treatment," "was able to distribute this book
134:15 to every licensed physician and physician assistant
134:16 in West Virginia."
134:17 And it says it's a "150-page book by
134:18 pain expert Scott Fishman, M.D." Do you know why
134:19 the Board of Medicine distributed this guide to all
134:20 of its licensees?
134:21 A. I think the amount of addiction and deaths
134:22 due to opioids continued to increase, and the
134:23 Federation of State Medical Boards had worked with
134:24 Scott Fishman, who -- in his work in California,
135:1 and he produced this book and distributed it free
135:2 of charge to people.
135:3 Q. Okay.
135:4 A. In fact, he didn't benefit financially from
135:5 the book at all.
135:6 Q. Did the Board think that the book was a
135:7 good book to guide physicians on how to responsibly
135:8 prescribe opioids?
135:9 A. Yes, it was.
135:10 Q. And the newsletter states that "the
135:11 response to the book has been quite positive." Do
135:12 you know what that meant?
135:13 A. I think people -- I think physicians found
135:14 it helpful to gain a better understanding of
135:15 opioids, the dangers of them and how to best

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	135:16 prescribe them and what circumstances. 135:17 Q. Okay. Was the Board influenced by any 135:18 wholesale drug distributors to distribute this 135:19 book? 135:20 A. No. It came through the Federation of 135:21 State Medical Boards.	
135:22 - 136:01	**Knittle, Robert 08-27-2020 (00:00:12)** 135:22 Q. Okay. Was the Board influenced by any drug 135:23 manufacturers to distribute this book? 135:24 A. No. Again, it was through the medical 136:1 board, the FSMB.	VM31.86
136:02 - 136:23	**Knittle, Robert 08-27-2020 (00:01:14)** 136:2 Q. Okay. Besides the response being quite 136:3 positive, do you recall any comments or information 136:4 from any of the licensees regarding the book 136:5 itself? 136:6 A. The book? No, other than that the people 136:7 that had read it felt that it was beneficial to 136:8 them. We actually had -- Scott Fishman presented 136:9 at the Federation of Medical -- State Medical 136:10 Boards at one of their national conventions, and 136:11 one of his biggest concerns was the death rate and 136:12 the amount of addiction in West Virginia. 136:13 So we asked him to come and speak to 136:14 us, and we had Doctor Fishman come to West Virginia 136:15 and, you know, through the physicians health 136:16 program and be a speaker for several hundred 136:17 people, which was very helpful. 136:18 Q. Do you recall when that was? 136:19 A. No, I think it was after the book was 136:20 published. 136:21 Q. Okay. 136:22 A. What year was this? 136:23 Q. It was spring of 2008.	VM31.87
137:14 - 137:22	**Knittle, Robert 08-27-2020 (00:00:18)** 137:14 Q. Were licensees of the Board invited to 137:15 attend -- 137:16 A. Yeah. 137:17 Q. -- Mr. Fishman's presentation? Okay. 137:18 A. They were.	VM31.88

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	137:19 Q. Did they receive any continuing education 137:20 credits to attend? 137:21 A. I believe it was managed through the 137:22 physicians health program that they did.	
138:12 - 142:21	**Knittle, Robert 08-27-2020 (00:06:12)** 138:12 Q. All right. Will you pull out Tab 11? 138:13 KNITTLE DEPOSITION EXHIBIT NO. 11 138:14 (Management of Pain Act passed April 138:15 8, 2009 was marked for identification 138:16 purposes as Knittle Deposition Exhibit 138:17 No. 11.) 138:18 A. Okay. 138:19 Q. All right. And this will be marked as 138:20 Exhibit 11 to your deposition, and this is the 138:21 Management of Pain Act passed April 8th, 2009. Do 138:22 you see that? 138:23 A. Uh-huh. Yes, I do. 138:24 Q. Okay. And this looks to be kind of an 139:1 iteration or an update of the legislation we 139:2 discussed earlier that was Exhibit 7. 139:3 A. Yes. 139:4 Q. Are you familiar with the Management of 139:5 Pain Act? 139:6 A. Yes. I think this was an amended version 139:7 of the previous one. 139:8 Q. Okay. Did the Board of Medicine have any 139:9 involvement in the drafting of the Management of 139:10 Pain Act? 139:11 A. I think we probably were cognizant of it as 139:12 it was being amended and probably had some level of 139:13 thumbs up or thumbs down on it or modification. 139:14 Q. But the Board itself wouldn't write the 139:15 text of it. It would kind of be presented to the 139:16 Board to say, "Do you agree with this"? 139:17 A. Yeah. I don't think it was initiated by 139:18 us. I think it was in -- it was the legislature 139:19 and -- yeah, legislators who prompted it. 139:20 Q. Okay. If you compare it to the 1998 one, 139:21 the title of it is a little bit different. The 139:22 1998 one says "Management of Intractable Pain" and	**VM31.89**

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139:23 the 2009 version is just "Management of Pain Act."
139:24 A. Uh-huh.
140:1 Q. And if you look at the definition -- do you
140:2 have the 1998 version in front of you too?
140:3 A. No, I don't.
140:4 Q. Could you grab that one?
140:5 A. Okay. Which tab was it?
140:6 Q. It was Tab 2.
140:7 A. Okay.
140:8 Q. If you look at the definition of
140:9 "Intractable pain" in the 1998 version -- just read
140:10 that over. It's number (3) in the first -- under
140:11 Article 3A.
140:12 A. Yes, I have it.
140:13 Q. Okay.
140:14 A. So that's intractable pain in the '98
140:15 version?
140:16 Q. And then if you look at the 2009 version,
140:17 there is no definition for intractable pain, but
140:18 there is a definition for "pain."
140:19 A. Yes.
140:20 Q. Okay. And the definition of "pain" in the
140:21 2009 version is "'Pain' means an unpleasant sensory
140:22 and emotional experience associated with actual or
140:23 potential tissue damage or described in terms of
140:24 such damage."
141:1 If you compare the definitions of
141:2 "intractable pain" versus just "pain," would you
141:3 agree with me that the definition of "pain" is a
141:4 bit broader than the definition of "intractable
141:5 pain"?
141:6 A. Yes, it is.
141:7 Q. Because "intractable pain" definition must
141:8 have a "cause that cannot be removed" and "pain"
141:9 does not have such language in its definition.
141:10 A. Right.
141:11 Q. Okay. And when you compare the two -- the
141:12 1998 version and the 2009 version, they are
141:13 virtually identical except for the 1998 version
141:14 will use the term "intractable pain" and the 2009

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	141:15 will use the term "pain."	
	141:16 Do you agree with me?	
	141:17 A. I didn't go through letter by letter --	
	141:18 Q. Okay.	
	141:19 A. -- but you say that they're exactly	
	141:20 identical?	
	141:21 Q. Nearly identical, yes.	
	141:22 A. All right.	
	141:23 Q. Okay. And in fact, the section on the 1998	
	141:24 version that we reviewed, the 30-3A-2(a)(1) and	
	142:1 (2) --	
	142:2 A. Yeah.	
	142:3 Q. -- is virtually identical. I think they --	
	142:4 one says "a physician shall not be subject" and the	
	142:5 other one "a physician is not subject." But other	
	142:6 than that, the definitions of "pain" versus	
	142:7 "intractable pain" is exactly the same.	
	142:8 A. Okay.	
	142:9 Q. So again, it would have been the position	
	142:10 of the Board of Medicine in 2009 that a physician	
	142:11 shall not or should not fear disciplinary action	
	142:12 just for prescribing opioids, correct?	
	142:13 A. Yeah, for the management of pain.	
	142:14 Q. And how would the Board of Medicine inform	
	142:15 its licensees of the change in the legislation?	
	142:16 A. Through newsletter. And through	
	142:17 distribution with the other entities.	
	142:18 Q. Okay. Was the Board of Medicine influenced	
	142:19 by any wholesale drug distributor related to the	
	142:20 creation of this 2009 legislation?	
	142:21 A. Not that I'm aware of, no.	
142:22 - 143:01	**Knittle, Robert 08-27-2020 (00:00:09)**	**VM31.90**
	142:22 Q. Okay. Was the Board of Medicine influenced	
	142:23 by any drug manufacturer related to the 2009	
	142:24 legislation?	
	143:1 A. Not that I'm aware of, no.	
143:02 - 143:23	**Knittle, Robert 08-27-2020 (00:01:40)**	**VM31.91**
	143:2 Q. Okay. All right. Can you grab Tab 15?	
	143:3 KNITTLE DEPOSITION EXHIBIT NO. 12	
	143:4 (Joint Policy Statement on Pain	

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	143:5 Management at the End of Life was 143:6 marked for identification purposes as 143:7 Knittle Deposition Exhibit No. 12.) 143:8 A. Did you say 15 or 16? 143:9 Q. 15. 143:10 A. Okay. 143:11 Q. All right. And this will be marked as 143:12 Exhibit 12 to your deposition, and it is the Joint 143:13 Policy Statement on Pain Management at the End Of 143:14 Life, and if you turn to page 4, it says that it 143:15 was originally adopted March 12th, 2001 and 143:16 re-adopted May 10th, 2001 by the West Virginia 143:17 Board of Medicine. Do you see that? 143:18 A. Yes, I do. 143:19 Q. Okay. So this is -- appears to be exactly 143:20 the same Joint Policy Statement on Pain Management 143:21 at the End of Life that we discussed earlier that 143:22 was Exhibit 8? 143:23 A. Yes.	
145:06 - 145:09	**Knittle, Robert 08-27-2020 (00:00:09)** 145:6 Q. Was the Board influenced by any wholesale 145:7 drug distributors to relook at all of its policies 145:8 during this time? 145:9 A. No.	VM31.92
145:22 - 147:06	**Knittle, Robert 08-27-2020 (00:01:33)** 145:22 KNITTLE DEPOSITION EXHIBIT NO. 13 145:23 (Policy for the Use of Controlled 145:24 Substances for Treatment of Pain dated 146:1 May 10, 2010 was marked for 146:2 identification purposes as Knittle 146:3 Deposition Exhibit No. 13.) 146:4 A. Okay. I have it. 146:5 Q. And this exhibit will be marked as Exhibit 146:6 13 to your deposition and the number on the bottom 146:7 of the first page is WV_BOM00001291. And if you 146:8 turn to the second page, it says it's the Policy 146:9 for the Use of Controlled Substances for Treatment 146:10 of Pain. 146:11 And similar to the policy that we just 146:12 looked at, if you go to the last page, this is also	VM31.93

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	146:13 re-adopted on May 10th, 2010 by the Board of 146:14 Medicine. And this appears to be identical to the 146:15 policy from 2005 that we discussed earlier. 146:16 Is this the same situation of the other 146:17 one, it was just the Board was looking at 146:18 everything it had, and if it agreed with the 146:19 language, it re-adopted it; if it needed to change 146:20 anything, they would change the language. 146:21 A. Yes. I think if you look at all of our 146:22 policies for that time period, over a course of a 146:23 couple of meetings, we went through all our 146:24 policies. 147:1 Q. Okay. So it would have been the position 147:2 of the Board in -- that its Policy for the Use of 147:3 Controlled Substances for the Treatment of Pain did 147:4 not need to change at all from January of 2005 to 147:5 May of 2010. 147:6 A. Right.	
148:23 - 149:06	**Knittle, Robert 08-27-2020 (00:00:19)** 148:23 Did the Board of medicine ever 148:24 promulgate rules for the licensure of pain 149:1 management clinics? 149:2 A. I believe they did, yes. 149:3 Q. Okay. Do you know what they were? 149:4 A. No. I know that we had to monitor them and 149:5 that there were certain stipulations that they had 149:6 to abide by.	**VM31.94**
153:20 - 154:04	**Knittle, Robert 08-27-2020 (00:00:22)** 153:20 Q. What did the Board do to designate a person 153:21 to access the CSMP database? 153:22 A. I recommended to the Board that our 153:23 investigator be the lead person for -- to access 153:24 it. 154:1 Q. And did the Board accept that 154:2 recommendation? 154:3 A. I believe they did, yes. I did not have 154:4 access to it.	**VM31.95**
158:24 - 159:05	**Knittle, Robert 08-27-2020 (00:00:01)** 158:24 KNITTLE DEPOSITION EXHIBIT NO. 15 159:1 (Model Policy on the Use of Opioid	**VM31.96**

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	159:2 Analgesics in the Treatment of Chronic 159:3 Pain was marked for identification 159:4 purposes as Knittle Deposition Exhibit 159:5 No. 15.)	
159:09 - 159:19	**Knittle, Robert 08-27-2020 (00:00:29)** 159:9 Q. All right. And this will be marked as 159:10 Exhibit 15 to your deposition. Do you recognize 159:11 this document? 159:12 A. I do. 159:13 Q. Okay. And what is it? 159:14 A. It's the policy for the use of opioid 159:15 analgesics for the treatment of chronic pain that 159:16 was put out by the Federation of State Medical 159:17 Boards. 159:18 Q. And it's dated July 2013? 159:19 A. It is.	VM31.97
162:09 - 162:12	**Knittle, Robert 08-27-2020 (00:00:12)** 162:9 Q. Do you know if FSMB was influenced in any 162:10 way by any wholesale drug distributors to create 162:11 the 2013 model policy? 162:12 A. No, I do not.	VM31.98
162:18 - 163:09	**Knittle, Robert 08-27-2020 (00:00:29)** 162:18 KNITTLE DEPOSITION EXHIBIT NO. 16 162:19 (WVBOM Policy on the Use of Opioid 162:20 Analgesics in the Treatment of Chronic 162:21 Pain was marked for identification 162:22 purposes as Knittle Deposition Exhibit 162:23 No. 16.) 162:24 A. Okay. 163:1 Q. All right. So this says these are the 163:2 Board of Medicine's Policy on the Use of Opioid 163:3 Analgesics in the Treatment of Chronic Pain and 163:4 dated July 2013. And it says they are adopted from 163:5 the model policy guidelines of the Federation of 163:6 State Medical Boards. 163:7 Would those be the July -- the July 163:8 policy that we just talked about? 163:9 A. Yes.	VM31.99
163:15 - 163:20	**Knittle, Robert 08-27-2020 (00:00:24)** 163:15 Q. Do you know if the Board made any changes	VM31.100

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	163:16 to the FSMB model policy? 163:17 A. I don't believe that they did. I know that 163:18 they reviewed it carefully, it being a new policy 163:19 with a lot more information in it, but I don't 163:20 think they made any policy -- any changes in it.	
164:03 - 164:13	**Knittle, Robert 08-27-2020 (00:00:41)** 164:3 Q. What was the purpose of the Board adopting 164:4 the Policy on the Use of Opioid Analgesics in the 164:5 Treatment of Chronic Pain? 164:6 A. I think it was to have a -- just a common 164:7 understanding across the nation as to how -- how 164:8 you should use opioid analgesics for the treatment 164:9 of chronic pain. We wanted to try to get it as 164:10 uniform as possible from state to state in terms of 164:11 language and expectation of physicians. 164:12 You know, moving from, you know, West 164:13 Virginia to Texas to South Dakota to California.	VM31.101
164:18 - 165:05	**Knittle, Robert 08-27-2020 (00:00:32)** 164:18 Q. All right. The second, I guess, full 164:19 paragraph - even though it's only a sentence - says 164:20 "The CSA does not limit the amount of drug 164:21 prescribed, the duration for which it is 164:22 prescribed, or the period for which a prescription 164:23 is valid (although some states do impose such 164:24 limits)." 165:1 Do you know if West Virginia imposes 165:2 limits? 165:3 A. No, we did not. We didn't cap anything. 165:4 I'm trying to think of a state that did, and I 165:5 can't recall one.	VM31.102
166:04 - 166:19	**Knittle, Robert 08-27-2020 (00:00:52)** 166:4 Q. And during your tenure at the Board, did 166:5 the Board have licensees that illegally prescribed 166:6 opioids? 166:7 A. Yeah, there were a number of them that 166:8 ended up being criminally prosecuted. 166:9 Q. Okay. And what was their criminal intent? 166:10 A. I believe that their intent was -- was 166:11 financial in nature. 166:12 Q. Okay. Do you know of any board licensees	VM31.103

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	166:13 that illegally prescribed in Cabell County? 166:14 A. I believe that there were. I can't give 166:15 you their names. And there were some that 166:16 prescribed in Cabell County and other counties, 166:17 surrounding counties, as well. 166:18 But there were some that -- that were 166:19 criminal in their -- in their actions.	
167:14 - 167:21	**Knittle, Robert 08-27-2020 (00:00:21)** 167:14 Q. Okay. Was the Board of Medicine influenced 167:15 in any way by any wholesale drug distributors to 167:16 adopt the policy on the use of opioid analgesics in 167:17 the treatment of chronic pain? 167:18 A. No. 167:19 Q. Was the Board influenced by any 167:20 manufacturers? 167:21 A. Not that I'm aware of.	VM31.104
168:10 - 168:24	**Knittle, Robert 08-27-2020 (00:00:49)** 168:10 Q. All right. This will be marked as Exhibit 168:11 17 to your deposition. And it is the West Virginia 168:12 Board of Medicine Quarterly Newsletter, Volume 17, 168:13 Issue 3, July through September of 2013. Correct? 168:14 A. Yes, it is. 168:15 Q. Okay. On page 2, it says, "Update On Board 168:16 Policies." So is this kind of like how we talked 168:17 about for many of the other policies, that the 168:18 Board would put information in the newsletter about 168:19 changes in policies? 168:20 A. Yes. 168:21 Q. And so this one is talking about the Policy 168:22 on the Use of Opioid Analgesics in the Treatment of 168:23 Chronic Pain. And that would be Exhibit 16 that we 168:24 just discussed. Right?	VM31.105
169:01 - 169:24	**Knittle, Robert 08-27-2020 (00:01:26)** 169:1 A. Yes. 169:2 Q. Okay. And the second full paragraph, the 169:3 first sentence, says, "The Board continues 169:4 overtreatment and the continued use of ineffective 169:5 treatments to be the most common and problematic 169:6 iterations of the inappropriate treatment of pain." 169:7 What is "overtreatment"?	VM31.106

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	169:8 A. "Overtreatment" would be overprescribing, 169:9 prescribing multiple medications. 169:10 Q. And what is the "continued use of 169:11 ineffective treatments"? 169:12 A. To continue a treatment regimen that is 169:13 ineffective. 169:14 Q. What options would a prescriber have if 169:15 opioid therapy was ineffective? 169:16 A. I think there's a number of them. I 169:17 couldn't tell you, again, not being a physician. I 169:18 know that there are some good pain management 169:19 specialists out there who have developed pain 169:20 management without the use of opioids and have had 169:21 good success with it. 169:22 So I think they had to begin to look 169:23 at other options. 169:24 Q. Why were these the most common and	
170:01 - 170:13	**Knittle, Robert 08-27-2020 (00:00:47)** 170:1 problematic iterations of the inappropriate 170:2 treatment of pain in 2013? 170:3 A. I think probably we were looking at the 170:4 complaints and things we had that people were 170:5 overprescribing; people continued to provide 170:6 opiates at higher dosages although there was no 170:7 indication that there was any effectiveness 170:8 whatsoever. 170:9 And more information was coming out 170:10 that opioids often do not control pain very well. 170:11 Q. Where was that information coming from? 170:12 A. I believe it was coming from medical 170:13 associations, medical journals across the nation.	**VM31.107**
178:07 - 180:01	**Knittle, Robert 08-27-2020 (00:02:30)** 178:7 KNITTLE DEPOSITION EXHIBIT NO. 21 178:8 (WV Legislature 2016 Regular Session 178:9 Enrolled Senate Bill 627 was marked 178:10 for identification purposes as Knittle 178:11 Deposition Exhibit No. 21.) 178:12 A. Okay. 178:13 Q. All right. This may look familiar, but 178:14 this will be marked as Exhibit 21 to your	**VM31.108**

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178:15 deposition. And if -- the front says it's passed
178:16 March 10th, 2016, and if you turn to the next page,
178:17 it's the Management of Intractable Pain Act.
178:18 A. Yes.
178:19 Q. So we have previously discussed two prior
178:20 versions of this, the 1998 and the 2009 versions,
178:21 correct?
178:22 A. Yes.
178:23 Q. Was the Board involved in the drafting of
178:24 this 2016 version?
179:1 A. I believe we were, but I don't recall the
179:2 circumstances of it. There was a -- there was a
179:3 reason why it was -- it was moot -- or it was -- or
179:4 amended.
179:5 Q. Okay. And if you look on the second page,
179:6 the top paragraph, says, "An Act to amend and
179:7 reenact Section 30-3A-2 of the Code of West
179:8 Virginia, 1931, as amended; and to amend and
179:9 reenact Section 55-7-23 of said code, all relating
179:10 to permitting physicians to decline prescribing
179:11 controlled substance in certain circumstances;
179:12 limiting disciplinary action by a licensing board
179:13 on a health care provider with prescriptive
179:14 authority for declining to prescribe, or declining
179:15 to continue to prescribe, any controlled substance
179:16 in certain circumstances and providing that a
179:17 health care provider with prescriptive authority is
179:18 not liable to a patient or third party for
179:19 declining to prescribe, or declining to continue to
179:20 prescribe, any controlled substance in certain
179:21 circumstances."
179:22 So the amendment seems to be trying to
179:23 address the issue where a physician was declining
179:24 to prescribe a controlled substance.
180:1 A. Yes.

181:23 - 182:05	**Knittle, Robert 08-27-2020 (00:00:19)**	**VM31.109**

181:23 Q. And prior to this amendment, if the Board
181:24 had received a complaint regarding a physician not
182:1 prescribing opioids, would the Board have
182:2 disciplined that physician?

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	182:3 A. I think we would looked -- would have 182:4 looked into the complaint to see if there was any 182:5 merit.	
191:17 - 193:20	**Knittle, Robert 08-27-2020 (00:02:42)** 191:17 Q. And how did the Board try to identify the 191:18 prescribers who were contributing to the alarming 191:19 and sad situation? 191:20 A. Through complaints. We can't go fishing -- 191:21 you can't go into the CSMP and start looking and 191:22 saying, "Oh, okay, who's the biggest prescribers 191:23 here?" That's, you know, grossly illegal, and it 191:24 was not the purpose of the CSMP, and there was a 192:1 lot of caution against that kind of activity where 192:2 they could -- that information could be used 192:3 detrimentally towards people. 192:4 So, you know, we function by 192:5 complaints, the complaint process, and we really 192:6 can't -- are not authorized to do anything unless 192:7 there's a complaint. 192:8 Q. And why would just going into the CSMP - if 192:9 you had the ability - to say, "Who's the biggest 192:10 prescriber," why wouldn't that do anything for you? 192:11 I mean, would you have wanted to be able to do 192:12 that? 192:13 A. No. No. And it would not be for -- for 192:14 the Board of Medicine. It would be for law 192:15 enforcement. That -- you know, if they have a -- 192:16 someone under suspicion, they can't pull up that 192:17 information and then say, "Oh, okay, well, so-and- 192:18 so's -- you know, look at this, you know, he has 192:19 two different doctors prescribing to him, let's -- 192:20 let's monitor him and then pick it up." 192:21 You know, which is illegal. So -- or 192:22 people using it to get information against 192:23 somebody. You know, there was an instance of -- 192:24 that I had heard of where someone had found 193:1 information on their ex-wife. So, you know, that's 193:2 a -- you can -- you can use it -- you can use it in 193:3 a lot of criminal ways, and there was a great deal 193:4 of effort to make sure that that didn't happen.	VM31.110

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193:5 Q. And just going in and getting information
193:6 on the biggest prescriber wouldn't tell you
193:7 anything. The biggest prescriber could be working
193:8 in hospice where it's end-of-life care and of
193:9 course they're the biggest prescriber --
193:10 A. Right.
193:11 Q. -- that type of situation.
193:12 A. Right.
193:13 Q. The numbers --
193:14 A. That was just a -- that was just a, you
193:15 know, a possibility, throw it out in the air.
193:16 Q. Yeah.
193:17 A. But you know, you're exactly right.
193:18 Q. Yeah. The numbers alone don't tell you
193:19 anything.
193:20 A. Right.

193:21 - 194:22 **Knittle, Robert 08-27-2020 (00:01:52)** VM31.111

193:21 Q. Okay. Can you pull out Tab 36?
193:22 KNITTLE DEPOSITION EXHIBIT NO. 42
193:23 (WVBOM June 2016 Newsletter was marked
193:24 for identification purposes as Knittle
194:1 Deposition Exhibit No. 24.)
194:2 A. Okay.
194:3 Q. Perfect. This will be marked as Exhibit 24
194:4 to your deposition. And this is the June 2016 West
194:5 Virginia Board of Medicine newsletter, correct?
194:6 A. Yes.
194:7 Q. And if you turn to page 6.
194:8 A. Okay.
194:9 Q. The title is "Reducing Risk:
194:10 Opioid-Prescribing Guideline Developed by CDC."
194:11 And the first full paragraph states, "Since 2006,
194:12 West Virginia has been the epicenter for
194:13 prescription drug overdose deaths in the nation.
194:14 This primarily has been fueled by the liberal
194:15 prescription of opioids over the past decade,
194:16 unfortunately compounded by overdose deaths from
194:17 heroin and illicitly-produced fentanyl."
194:18 So in -- in at least 2016, it was the
194:19 Board's belief that the opioid epidemic was

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	194:20 primarily fueled by doctors liberally prescribing 194:21 opioids, correct? 194:22 A. Yes.	
196:07 - 196:24	**Knittle, Robert 08-27-2020 (00:01:14)** 196:7 Q. For -- I'm sorry. For all of the 196:8 guidelines that we've discussed, including the 196:9 adoption of the 2013 FSMB guidelines, the Board 196:10 would have relied on the judgment of the medical 196:11 professionals on the Board as to whether to accept 196:12 or adopt those guidelines, correct? 196:13 A. Yes. 196:14 Q. Okay. And when the Board adopted the FSMB 196:15 2013 guidelines, did they make that decision 196:16 independent from the FSMB, or did the FSMB request 196:17 that the Board adopt the guidelines? 196:18 A. No, it was -- it was their own independent 196:19 decision. You know, the guidelines were put out by 196:20 the FSMB, but there was no coercion on anyone's 196:21 part to adopt or adopt portions of it or however. 196:22 With 50 different states, you know, there's -- it 196:23 was made available to everyone to use it as they 196:24 saw fit.	VM31.112
201:04 - 202:16	**Knittle, Robert 08-27-2020 (00:01:35)** 201:4 Q. As you discussed earlier, one of the 201:5 Board of Medicine's functions is to license 201:6 doctors and other medical professionals, 201:7 correct? 201:8 A. That's correct. Allopathic 201:9 physicians. 201:10 Q. How often do doctors have to be 201:11 relicensed by the Board? 201:12 A. Every two years. 201:13 Q. And what is the purpose of licensing 201:14 doctors? 201:15 A. In order to ascertain that they are 201:16 still practicing with a proper degree of 201:17 knowledge and professionalism. 201:18 Q. So the Board's license is an 201:19 endorsement of the doctor's credentials? 201:20 A. Yes.	VM31.113

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	201:21 Q. And the Board's license is an 201:22 endorsement of the doctor's ability to 201:23 continue to make medical judgments? 201:24 A. Yes. 202:1 Q. And part of the reason that the Board 202:2 of Medicine licenses doctors is to protect the 202:3 public; is that right? 202:4 A. That's correct. 202:5 Q. So the public can have confidence that 202:6 a licensed doctor is legitimate? 202:7 A. Yes. 202:8 Q. And licenses ensure that only doctors 202:9 can prescribe controlled substances? 202:10 A. I think physicians, yes. 202:11 Q. And if the Board of Medicine knew that 202:12 a doctor was engaged in diversion of 202:13 controlled substances, they have the authority 202:14 to pull the doctor's license through the 202:15 disciplinary procedures we talked about? 202:16 A. Through the disciplinary process, yes.	
202:17 - 202:24	**Knittle, Robert 08-27-2020 (00:00:20)** 202:17 Q. And the Board of Medicine also has the 202:18 authority to decide not to relicense a doctor? 202:19 A. It would have to have a basis for 202:20 doing so. 202:21 Q. If the Board of Medicine knew that a 202:22 doctor was engaged in diversion of controlled 202:23 substances, would they have the authority to 202:24 decide not to re-license a doctor?	**VM31.114**
203:01 - 203:04	**Knittle, Robert 08-27-2020 (00:00:10)** 203:1 A. It would have to be proven through the 203:2 complaint process for that to occur. We 203:3 couldn't just randomly say, "Well, we don't 203:4 think we're gonna give you your license back."	**VM31.115**
203:05 - 204:01	**Knittle, Robert 08-27-2020 (00:01:20)** 203:5 Q. So if a doctor/licensee went through 203:6 the disciplinary process and was found to have 203:7 engaged in diversion of controlled substances, 203:8 the Board of Medicine would have the authority 203:9 to decide not to relicense a doctor at that	**VM31.116**

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203:10 point.
203:11 A. It would be a revocation of his
203:12 license with the -- with the possibility that
203:13 he would not be able to renew again.
203:14 Q. What is the -- what information does
203:15 the Board of Medicine look at when it decides
203:16 whether or not to license a doctor?
203:17 A. We would look at -- there's a series
203:18 of questions that the physician must answer -
203:19 I think there's 12 or 15 of them - that has to
203:20 do with their mental fitness, their physical
203:21 fitness, any issues with possible addictions
203:22 themselves, any court issues or legal issues
203:23 that may affect their practice.
203:24 And there's a -- there's a list
204:1 of those on the page for the renewal section.

Defendants' Affirmatives = 00:57:58
Defendants' Completeness = 00:02:27
Plaintiffs' Completeness = 00:31:49
Total Time = 01:32:14